General Medical Council complaints: swimming against the stream

The General Medical Council receives over 5000 complaints every year.[1] On 17 October 2005 a new procedure came into effect that will mean some complaints will now be referred to the local health service or primary care trust.[1] Scaling down the complaints procedure in this way exposes it to claims of unfairness and partiality that could weaken the public's faith in the way complaints are dealt with and undermine their trust in doctors generally.

The General Medical Council has the ultimate power to restrict or remove a doctor's ability to practice. It is vital that this quasi-judicial authority is not only exercised properly but is seen to be exercised properly when careers, reputations and patient care are at stake.

Most complaints received by the General Medical Council are not concerned with issues that may entail a doctor being struck off.[1] Accordingly, it believes many would be best dealt with at a local level because local health service trusts or primary care trusts can be better placed to examine the patient's complaint and identify any governance issues that may have arisen.[2] Would a local trust complaints officer really be more objective than an independent General Medical Council screener?

The General Medical Council will now make an initial assessment of each complaint it receives and distinguish between those that are sufficiently serious to warrant further investigation itself and those that it can refer to the relevant local health service or primary care trust to deal with under their own complaints procedures.[1] The more serious complaints procedure will be referred to as stream one and the less serious procedure referred to as stream two. Guidelines are yet to be provided on what will differentiate the two streams. It is crucial that the distinguishing factors of each route are assimilated quickly and applied consistently between trusts.

In some cases where the patient may have to have further contact with the doctor concerned, this might put both parties in a difficult position and deter the patient from making the complaint in the first place. The doctor involved will also be placed in an impossible position that may prejudice his or her ability to perform their job.

Once the complaints officer of the relevant local health service trust or primary care trust has assessed the complaint they are able to refer it straight back to the General Medical Council at any time if their investigation leads them to conclude the case is sufficiently serious.[1] If the complaints officer does not have sufficient resources to investigate or manage a complaint properly they may be tempted to refer it back to the General Medical Council asking them to undertake a full investigation. Such a course of action could potentially add months to the complaints procedure causing unnecessary distress to both the patient and doctor.

The stream two complaints procedure also calls into question the role of other forums within the National Health Service for protecting patients and supporting doctors. For example, the National Clinical Assessment Service is an existing body with the power to investigate doctors whose practice gives rise to serious concerns. The new stream two procedure begs the question: what distinguishes it from the National Clinical Assessment Service strategically?

The main concern for the trusts in properly executing the new procedure is one of resources. It is highly unlikely that the trusts will be given more funding to cope with the additional workload. The General Medical Council will have to be kept informed of developments in each case that they refer which will add another layer of bureaucracy to the process. The procedure will also expose the complaints officers to a much wider range of complaints. Will they be equipped to analyse the increased quantities of evidence? Real concerns have arisen for both doctors and departmental managers about the appropriate levels of experience, training and skill that complaint managers currently have to manage complaints about potentially complex issues of medical practice. Without proper funding there will be no imperative to investigate complaints properly. Without sufficient resources there will be delays and a temptation to take short cuts with repercussions for both the patients and doctors concerned.

Consider a patient whose complaint about a doctor is upheld by the local trust complaints department. The doctor will be keenly aware of those who investigate the complaint, review the evidence and make the final decision, and of all the internal trust politics surrounding those individuals. In such circumstances personal integrity will be challenged. Conversely, in a case where a patient's complaint is not upheld against a doctor there will be doubts about the objectivity of the decision made by one trust employee about another. In both examples, however, it is the structure of the new complaints system that undermines its validity—there is insufficient distance between the person making the complaint and the subject of the complaint.

Now that stream two type complaints will not be considered by the unifying General Medical Council we will lose a body of decisions that could be read in the same way

that lawyers approach case law; which ensures a uniformity of interpretation of the rules. Inconsistencies, which are bound to develop in the decisions that different trusts take, will be exploited. As faith in the system deteriorates there will be more appeals: the very purpose of the new procedure to speed up the resolution of complaints will have failed.

Doctors must be concerned about a procedure in which they will be judged by people within the same political and competitive environment. Patients, too, will have their doubts about the objectivity of a complaints process where those who investigate and those who are being investigated are so close to one another. Article 6 of the *Human Rights Act 1998* provides the right to a fair trial. It will be interesting to see how often it gets invoked to challenge the spectre of prejudice in stream two complaints procedures.

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2 General Medical Council. *GMC Changes Complaints Handling Process,* Press Release17.10.05. London: GMC, 2005 [www.gmcpressoffice.org.uk/apps/news/latest/detail.php?key=191] Accessed 17.1.06

'Open-access' publishing: first the evidence—then the verdict

'Nec audiendi sunt ii qui volent dicere, vox populi vox Dei, cum tumultuositas vulgi semper insaniae proxima est' [ignore those who say that the people's voice is God's voice—mob-led panic is ever akin to madness; Alcuin, in a letter to Charlemagne (804)]

> 'No!' said the Queen, 'first the sentence, and then the evidence!' [Lewis Carroll, *Alice's Adventures Underground* (1864)]

We respect the medieval proverb *vox populi vox dei* in many walks of life, perhaps increasingly today, with vox pop so readily accessible. *Vox populi* (or at least *suffragia populi*) elects governments, although in return governments generally prefer to ignore it: in the UK it takes major dissent to deflect a government from its plans, and referenda are rare. The jury system also enshrines the principle, and when important matters are undecided we say that the jury, a sort of focus group, is still out.

Focus groups as vox pop are a legitimate method of research in the social sciences, if used correctly and for proper ends.[1] They can generate hypotheses or help in constructing questionnaires for larger studies, and they can uncover factors that affect people's behaviour, suggesting potential methods of altering that behaviour. However, using focus groups to inform political policy (popular in recent years) is risky, because they do not necessarily reflect the opinions of the majority; even if they do, the majority opinion does not necessarily dictate the best policy (buy *The Sun*—six million readers can't be wrong).

In this issue of the *JRSM*, Schroter and Tite report the results of a questionnaire study on knowledge of open-access publishing and attitudes to it.[2] Questionnaire studies in large populations can yield useful insights into what people know or believe. However, they are not suitable for some types of study.[3] For example, don't ask doctors about their professional behaviour—they consistently overestimate their performance.[4] Schroter and Tite found that their respondents, authors of research papers, knew and understood little about open-access publication and its implications. Are their other findings valid or useful? I don't know, but I have doubts. For example, bias in answering questions could have been reduced by sending half the sample a similar questionnaire with questions couched in opposite terms (e.g. negative for positive), but that was not done. Do their findings reflect the true opinions of a group of individuals whose views should be influential? Perhaps not: some were inexperienced in research and publishing; others confessed that they knew nothing about open access. And, however well-informed the opinions, the results tell us nothing about the important issue: whether open-access publishing will on balance benefit research and its safe dissemination.

Open-access publishing has many different definitions,[5] but it is based on the idea that research findings should be made available immediately to everyone, via the author,